Mississauga Halton **LHIN**
RLISS de Mississauga Halton

Mississauga Halton
Local Health Integration Network

Annual Business Plan

April 1, 2011 – March 31, 2012

Ontario
Local Health Integration Network

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June 30, 2011

Mr. Alex Bezzina
Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long Term Care
5th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1R3

Re: Mississauga Halton Local Health Integration Network – Annual Business Plan 2011-12

Dear Mr. Bezzina:

I am pleased to provide a copy of the Board approved 2011-12 Annual Business Plan (ABP) for the Mississauga Halton Local Health Integration Network.

As per the guidelines provided by the Ministry of Health and Long Term Care, the draft 2011-12 ABP content requirements have been revised to reduce redundancy with other LHIN reporting requirements, concentrating on goals and action plans relating to system change and outcomes. This draft ABP operationalizes the three-year Integrated Health Service Plan (IHSP). Action plans for each of the priorities identified in the IHSP are presented using the template provided by the Ministry.

Sincerely,

Bill MacLeod
CEO

Encl

Mississauga Halton

Local Health Integration Network

Annual Business Plan 2011-12

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2. CONTEXT

The Annual Business Plan (ABP) is a key component of the Ministry of Health and Long Term Care (Ministry) and the Local Health System Integration Network (LHIN) accountability framework. It operationalizes the Integrated Health Service Plan (IHSP) by providing annual goals and action plans for each IHSP priority. It identifies actions and intended changes planned for the upcoming fiscal year 2011-12.

The information below summarizes the LHIN mandate and the local health system in which the LHIN operates.

2a. Mandate

The Mississauga Halton (MH) LHIN works to ensure the availability of, and access to, appropriate health care services that improves the overall health of the population. This is consistent with the MH LHIN vision of a seamless health system for our communities – promoting optimal health and delivering high-quality care when and where needed. The IHSP is a three year directional report that outlines key goals to achieve the vision. It is developed with input from residents, stakeholders, and health service providers (HSPs).

2b. Overview of MH LHIN's Current & Forthcoming Programs/Priorities

The MH LHIN funds 33 Community Support Services, 12 Mental Health & Addictions Agencies, one Community Care Access Centre (CCAC), 27 Long Term Care Homes and three Hospital Corporations (including six hospital sites). The MH LHIN holds Accountability Agreements with each of these agencies that describe the range and scope of services provided; fiscal resources required to sustain services and expected outcomes.

All organizations in the MH LHIN are guided by the Integrated Health Service Plan (IHSP) priorities for health system improvement. The MH LHIN's strategic priorities for 2010/11 to 2012/13 are as follows:

- Improving access, quality and sustainability of the health system
- Creation of MH LHIN-wide regional programs
- Prevention and management of chronic conditions
- Integrating mental health and addictions services
- Enhancing seniors' health, wellness and quality of life
- Strengthening primary health care

In addition to the six priorities listed above, six strategic enablers are identified in the IHSP as pillars to support our success in addressing all of our strategic priorities. We will also take action on the strategic enablers themselves through the ABP.

- Capacity increase
- Partnership for collaboration
- eHealth
- Transportation
- Engaged public about their personal health
- Health human resources

2c. Key Accomplishments – Improving Access, Quality and Sustainability

The MH LHIN is providing the right care at the right time in the right place for people in our communities. The MH LHIN manages over $1.25 billion in funding, of which only about one-third of one percent goes to LHIN operational services, providing excellent value.

The MH LHIN continues to build on the success in 2010/11 in the 2011/12 ABP. Key highlights of the last year's accomplishments within the IHSP Priorities, include:

I. Improving Community Service Capacity

1. Community Support and CCAC Services
    a) Expansion and Spread of the Home First Approach
    b) Building Community Service Capacity
        i. Expansion of the Assisted Living – Supports for Daily Living Program
        ii. Expansion of CCAC enhanced community services for the high needs seniors and palliative end of Life clients
    c) Transitional Care Capacity
        i. Implementation of the Behavioural Support Unit

Key Performance Results in 2010/11:

Measure	2009/10 Performance	2010/11 Performance	Result
% ALC Patient Days : acute	9.20%	Q3: 9.29%	Improved performance, approaching target of 8.3%.
Rate of Palliative deaths in hospital	51.80%	50.20%	Improved when compared to the same period of last year.
Rate of new LTC referrals from hospital	34%	30%	Improved by 4% compared to fiscal 09/10.
# of applicants on LTC Wait List	1,106	919	Improved with right people (who have no other choices) on the wait list when compared to the same time last fiscal.

2. Mental Health and Addictions Services
    a) Full implementation of the Community Concurrent Disorders Program, a collaboration of mental health and addictions agencies providing enhanced integrated community services to provide crisis management and case management support for individuals presenting in the ED.

Measure	2010/11 Performance	Result
Repeat Unplanned Emergency visits within 30 Days for Mental health conditions	Q1&2: 13.8%	Improving performance from 09/10 at 14.2% and moving toward 10/11 target of 12.6%
Repeat Unplanned Emergency visits within 30 Days for Substance Abuse conditions	Q1%2: 20.06%	Improving performance from 09/10 at 20.3% and moving toward 10/11 target of 17.4%

3. Improving LTC Capacity for High Needs/Frail Seniors
    a) Expansion of the Nurse Practitioner Program (NP Stat) to enhance liaison between hospital and LTC Homes for the repatriation or facilitation of high needs LTC residents back to their LTC homes.

Measure	2010/11 Performance	Result
Increase the number of Facilitated Transfers between hospital and LTCH: Reduce hospital LOS for residents/in patients who can be discharged to a LTC facility with appropriate supports provided by the Nurse-led Long Term Care outreach Team	Q2: 28	This data will be updated for fiscal 2010/11.

II. Improving Hospital Wait Times

1. ED Wait Times
    a) Through the efforts of hospitals' ED Pay for Results action plans improvement has been achieved in the non-admit ED wait times despite increased ED volumes.

Measure	2010/11 Performance	Result
90th percentile LOS for non-admitted Complex patients	6.70 hours	Exceeding target of 7.00 hours
90th percentile LOS for non-admitted minor uncomplicated patients	3.72 hours	Exceeding target of 4.00 hours
Reduce average ED Length of Stay for Admitted Patients	Reduced by 8.9 hours*	334,013 hours of ED wait time have been eliminated in 2010/11.

**From April 2008 baseline to March 2011.*

2. MRI and CT Wait times
    a) Diagnostic Imaging shared scheduling of appointments across the 3 hospitals to reduce wait times for service.

Measure	2010/11 Performance	Result
90th Percentile Wait time for Diagnostic MRI Scan	143 days	Did not achieve 2010/11 target of 121 days. Additional volume capacity in 2011 will assist to reduce wait times.
90th Percentile wait Time for Diagnostic CT Scan	27 days	Overall improvement, exceeded 2010/11 target of 35 days.

MISSISSAUGA HALTON LHIN PERFORMANCE INDICATORS
2010/11

PI No.	Performance Indicator	LHIN 10/11 Starting Point	LHIN 10/11 Performance Target	Most Recent Quarter 2010/11 LHIN Performance	FY 2010/11 LHIN Annual Result
1	90th Percentile Wait Times for Cancer Surgery	60	60	63	57
2	90th Percentile Wait Times for Cardiac By-Pass Procedures	37	37	35	34
3	90th Percentile Wait Times for Cataract Surgery	96	96	177	155
4	90th Percentile Wait Times for Hip Replacement	138	138	141	144
5	90th Percentile Wait Times for Knee Replacement	159	159	164	156
6	90th Percentile Wait Times for Diagnostic MRI Scan	121	121	141	143
7	90th Percentile Wait Times for Diagnostic CT Scan	38	35	38	27
8	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution***	9.21%	8.30%	9.29%	9.73%
9	90th Percentile ER Length of Stay for Admitted Patients	38.60	28.40	42.37	35.87
10	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	7.20	7.00	6.82	6.70
11	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4.10	4.00	3.70	3.72
12	Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions**	14.90%	12.60%	13.80%	14.30%
13	Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions**	20.40%	17.40%	20.06%	19.59%
15	Readmission within 30 Days for Selected CMGs**	13.10%	13.10%	13.97%	13.64%

** FY 2010/11 is based on only 2 quarters of data (Q1-Q2 2010/11) due to availability

*** FY 2010/11 is based on only 3 quarters of data (Q1-Q3 2010/11) due to availability

III. Capital Planning (Institutional Capacity)

1. Acute Care Capacity Plan
   a) The 15 year comprehensive acute care capacity plan has been completed, incorporating the three hospitals' six sites forecast of needs based on HBAM methodology.
2. Hospital Capital Projects
   a) Significant capital projects at all 3 hospitals progressing with support of Ministry's capital planning branch. With ministry approval of Post Construction Operating Plan funding, expanded operational hospital capacity is being implemented through 2010 and into 2011/12.
3. LTC New Development
   a) Trillium Health Centre has been given Ministry approval for the development of a new 220 bed LTC home on the hospital's THC-West Toronto site.

IV. Key Integration Initiatives

1. Chronic Disease Prevention and Management (CDPM):
    a) COPD Community Outreach: Integration through funding of a partnership pilot project to increase access to home based chronic disease management to reduce ED and hospital readmission rates and develop a community based approach to CDPM.
2. Transitional Care/Reactivation:
    a) Behavioural Support Unit at Sheridan Villa LTC Home: aligned with the provincial Behavioural Support System Strategy. This is an innovative integration through the coordination of services, interaction and medical supervision among Sheridan Villa, Trillium Health Centre, the CCAC, the mental health outreach team and the Alzheimer's Society.
3. Regional Programs:
    a) Specialized Geriatric Services: Integration through coordination and partnering amongst hospitals and outreach support to community HSPs to enhance specialized geriatric services for frail seniors with complex healthcare needs. Trillium Health Centre is the designated regional lead for a range of programs including Falls Prevention Program, geriatric and geriatric mental health outreach, urgent geriatric assessment clinics operated with a consistent standard across all 3 hospitals.
4. Quality Improvement:
    a) Hospital
        i. Regional Antibiotic Stewardship Program: Integration through coordination, as part of a quality initiative on infection control best practices across all 3 hospitals to reduce the hospital acquired infection rates.
        ii. Regional Physician credentialing: progress being made across the LHIN. It is expected to be fully completed in 2011/12.
    b) LTC Homes
        i. Launch of the Resident First Quality initiative with 8 LTC Homes.
        ii. Launch of the Behavioural Support Unit at Sheridan Villa LTC Home.

V. Community Engagement

Leadership and innovation in community engagement strategies, including Citizen Reference Panel, and adoption of consistent guidelines and plans ensures greater transparency and accountability by the LHIN.

2d. Major Priorities for the MH LHIN in 2011/12

There are several areas that inform the 2011/12 business plan that reflect both the MH LHIN and the government's priorities for 2011/12.

I. Enhanced Role in Quality

- Ontario's Excellent Care for All Strategy focuses on the delivery of quality, evidence-based services that provide real patient benefits.

- With the introduction of the new *Excellent Care for All Act, 2010* (ECFA):
    - Hospitals will now be required to develop and post annual quality improvement plans; and
    - The compensation of health care executives will be tied to the achievement of performance improvement targets under these plans, making them more accountable for the quality of patient care.

- These legislative requirements for improving the quality and value of the patient experience will eventually be implemented by the other sectors of the health care system as well.

- As the role of Health Quality Ontario (HQO) evolves, the MH LHIN will work with provincial partners and other LHINs to support the implementation of the quality agenda.

- The MH LHIN, along with its health service providers, are also focused on improving quality within the full healthcare system. More details about these initiatives are discussed in Section 3a), Improving Access, Quality and Sustainability of the Health System.

II. Program / Service Integration

The MH LHIN has focused integration efforts in a number of key program/service areas over the past three years to improve community service capacity and collaboration among health service providers, and to better coordinate referrals in the handoffs, particularly from hospital back to community agencies.

In 2011/12, the MH LHIN will continue to focus on the integration opportunities initiated in 2009/10, as well as new opportunities in the following areas:

Hospital Lead:

- Proposed merger of Trillium Health Centre and Credit Valley Hospital
- Regional Program for Maternal / Child
- Regional Program for Children and Youth
- Chronic Disease Prevention and Management (CDPM): COPD Community Outreach
- Transformation and Integration of hospital Complex Continuing Care (CCC) and Rehabilitation services

Community Lead:

- Ontario Behavioural Support System Project:
    i. Behavioural Support Unit, Sheridan Villa, including a first year evaluation
    ii. Behavioural Support Systems Pilot, implementation if MH LHIN approved for a pilot project

- Mental Health:
    i. Regional Program for Eating disorders for Children and Youth
    ii. Transitions from Youth to Adult Services
    iii. Explore opportunities for broader program integrations with community mental health and addictions health service providers

- Expanded CCAC Role: Integration through coordination and partnering of LHIN-wide agencies for CCAC centralized eligibility process for referrals to CCC/Rehab, Assisted Living and Adult day Service to improve the flow of clients/patients through the transition points across the continuum of health care services.

- Integrated Palliative Client Care: As a "Spotlight LHIN" for the Integrated Client Care Project – Palliative Care, in collaboration with the Ontario Association of CCAC, Health Quality Ontario, MH CCAC, hospital, CSS and hospice agencies to improve the system integration of palliative services across the continuum of care.

This work will be informed by our local health system needs identified in the MH LHIN Integrated Health System Plan (IHSP) and the provincial strategic directions, such as

a. The Mental Health and Addictions Strategy
b. Provincial Rehabilitation and Complex Continuing Care Expert Panel
c. Provincial Behavioural Support System Project
d. Strengthening Home Care Services in Ontario Strategy

III. Transition Points within the Health Care System

The MH LHIN has focused on the transition points within the health care delivery system to improve patient/client access and timely transfer to the most appropriate level of care within the continuum of services.

Key areas of focus will continue to be transition from hospital back to the community and inter- agency coordination:

- **Home First Approach:** Home First is an evidence-based, person-centred, transition management philosophy focused on keeping patients – specifically high needs seniors - safe in their homes for as long as possible with community supports. If/when acute hospital care is required, Home First aims to support patients to return home on discharge prior to assessment for and/or admission to a Long Term Care (LTC) home or other appropriate care setting. Under Home First, transferring patients from hospital to a LTC home is considered only after all other community options are considered.

- **Mental Health Services: Transitions from Youth to Adult Services**, including collaboration with Justice and Education services. This initiative is aimed at ensuring transitional aged youth 16 - 24 years receive seamless care when transitioning from the youth health care system to adult care. There are 22 adult and child and youth MH&A health service providers participating in the four month pilot which began in May 2011.

- The Ministry of Health and Long-Term Care has been working to develop a comprehensive 10 year Mental Health and Addictions Strategy which will help guide future policy direction, planning and strategic investments in Ontario's mental health and addictions system.

- The strategy has been guided by recent reports from the Minister's Advisory Group of consumers, family members, providers and researchers from across Ontario and the Select Committee on Mental Health and Addictions of the Legislative Assembly of Ontario Report in August 2010.

- While details of the Strategy are still forthcoming, the primary focus of the policy in the first three years will be children, especially in bridging the equity gap between services for children and adults. Another focus will be early intervention and youth justice workers.

- LHINs will be involved and will be concentrating on:
    i. Transitions from youth to adult services
    ii. Transitions from the community sector to acute and back
    iii. Transitions between health and justice
    iv. Participation in local service collaboratives led by Health Quality Ontario

IV. Building Service Capacity in the Community

The MH LHIN has invested more than $30 million through the ministry's Aging at Home funding over the past three years. With the expected continued growth in our communities, it is critical that the MH LHIN continue to focus on supporting the high-needs individuals, particularly the frail seniors in the community, to continue to improve the high quality of care and sustainability of the health care system. The MH LHIN will continue to review and evaluate the success of the Home first approach and associated investments in enhanced community based services, specialized LTC supports, the transitional services and the specialized regional programs supporting these efforts.

V. Investments in Efficiencies and Cost Prevention

- To manage the rate of growth in health spending to a sustainable level while protecting front-line service delivery of quality care, the government is introducing reforms that focus on providing services supported by evidence, improving quality and accountability in the sector, and increasing the value of investments in the health care system.

- Increased usage of the Ministry's population health-based allocation model (HBAM) will provide the information needed to support the strategic alignment of funding based on the principles of equitable access, equitable cost and money following the patient.

- The government's commitment to reducing Alternate Level of Care (ALC) pressures continues through its increased funding to the community services sector by approximately three per cent per year over the next three years.

- These investments will go to long-term care homes, home care and other community supports, assisted living services, and mental health and addictions services, with the goal of strengthening access to care in the home and the community where people want it.

- Additionally, the investments will improve the health system's capacity and ability to care for individuals after hospital discharge, and where possible, avoid costly hospitalization for a visit to the emergency room.

- It is worth noting that LHINs spend a very small amount of administration and far less than average organizations in the public and private sector. The MH LHIN manages over $1.25 billion in funding. Only 0.35% of our budget goes toward LHIN administration.

3. IHSP 2010-13 PRIORITIES

a. Improving Access, Quality and Sustainability of the Health System
   i. Capacity Strategy
b. Create LHIN-wide Regional Programs / Integrating Health Care in the MH LHIN
c. Prevention and Management of Chronic Conditions
d. Integrating Mental Health and Addictions Services
e. Enhancing Seniors' Health, Wellness and Quality of Life
f. Strengthening Primary Health Care
g. eHealth (enabler)
h. French Language Health Services
i. Engagement with Aboriginal People

3a) Improving access, quality and sustainability of the health system
Description:
Improving the health care system performance for improved access, quality and sustainability means that the focus is on improving the patient/client experience by accessing high-quality services for the right care, at the right time, at the right place, and at the right cost. To do this the MH LHIN will continue to focus in the following areas: a. Transformation of community-based services to serve high needs clients in community b. Expansion of transitional care to support reactivation and functional levels post acute care c. Expand hospital capacity and optimize operational efficiencies to improve quality of care and reduce Wait Times.
Current Status:
Home First Approach and investment in enhanced community services, such as Supports for Daily Living, Adult Day Programs, Respite Services, transportation services, and enhanced CCAC services for high needs seniors and palliative care clients, has contributed to the reduction in ALC patient days in hospital, and the reduction in LTC wait lists. The shift to serving higher needs clients in the assisted living program through the Supports for Daily living model has been confirmed through an independent evaluation of the program. **LTC Home Capacity to care for high need residents** has been enhanced through the outreach services of the geriatric mental health outreach program, ABI outreach, and the NP Stat program. In particular, the LTC Nurse Practitioners have developed a strong relationship with the hospitals and LTC homes in the LHIN to support the re-entry of LTC residents post and acute care episode, especially for the complex high need resident. **Interim LTC Bed Capacity** at Trillium Health Centre starting in August/September 2011. **The Mental Health and Addictions Concurrent Disorder Program** has reduced the re-visits to the ED and supported clients more effectively in the community **The LTC Restore Transitional Program** has improved the functional level of residents to enable them to return home. Positive results of this program were confirmed through and

independent evaluation. A pilot is being planned for utilization of 2 to 4 of the existing Restore beds as short term or 'express beds' for access from ED or the hospital short stay beds.

The Behavioural Support Unit at Sheridan Villa has assisted in reducing the length of stay in hospital for clients who need transitional support for responsive behaviours and has succeeded and successfully repatriating residents back to a LTC home. The challenge will be in sustaining a flow of patients once the occupancy level of the program has been maximized due to timing in accessing alternative placement of choice in LTC home.

Hospital Wait Times are expected to improve through the following initiatives:

- Expansion of hospital capacity through PCOP funding of completed capital projects at Trillium Health Centre and Credit Valley Hospital.
- Additional MRI hours with the ministry approval for an additional MRI at Trillium Health Centre.
- Ed Wait times, especially time for admitted patients should improve with the implementation of the hospital ED Action Plans, including short stay beds.

Improve Quality of Care

- Continue progress with the LTC Residents First Initiative.
- Implementation of accreditation for all Community Support Service agencies and Mental Health and Addictions agencies.
- Implementation of the Community Care Information Management (CCIM) provincial initiative to standardize an integrated information system, including the roll out of the OCAN, CHA and IAR systems.
- The Integrated Client Care Project - Palliative Care will be launched in spring 2011.
- Hospital quality improvement plans as part of the Excellent Care for ALL Act provides opportunities for hospital wide collaboration on quality improvement initiatives.

GOALS and ACTION PLANS
Goal(s)
▪ Improve access and quality of care for patients/clients through: ▪ Increased community capacity to service high needs clients as an alternative to the need to rely on hospital or LTC Homes as appropriate ▪ Improve LTC Home capacity to serve high needs clients ▪ Reduced hospital wait times for MRI services ▪ Reduced hospital wait times for ED admitted patients
Consistency with Government Priorities:
Aligns with government priorities, such as the ED/ALC Strategy, Seniors Friendly Hospital Strategy, Ontario Behavioural Support Services Project, Community Care Information Management (CCIM), Mental Health & Addictions Strategic Direction and the *Excellent Care for All Act*.

Action Plans/Interventions

	Stages of Project Implementation		
	2011/12	2012/13	2013/14
Home First focus on maintaining / improving 8% total ALC in hospital. The MH LHIN is already a leader in this area.	75%	15%	10%
Enhancing Transitional Care Capacity: • Behavioural Support Unit evaluation • Pilot Restore Express project within Restore Program **(C)**	100%		
Enhancing LTC Capacity: 21 interim beds at Trillium Health Centre. **(C)**	100%		
Enhancing LTC Capacity: New 220 bed LTC Home at Trillium Health Centre. **(C)**		25%	75%
Enhance Quality Care: Complete the LTC Resident First Collaborative with 8 MH LHIN LTC Homes.	100%		
Complete CSS and MH&A accreditation process.	30%	45%	25%
Complete CCIM provincial projects.	75%	25%	

How will we measure success?

Maintain or improve on performance targets outlined in **Figure 1** (page 15) for:

- Percentage ALC Patient Days
- 90th percentile for ED admitted wait times
- Rate of hospital referrals for LTC placement
- Reduction in number of applicants on LTC wait list

What are the risks/barriers to successful implementation?

- Ability to make the transformational shift to community based services within existing resources and community and hospital sector readiness
- Lack of alignment of current legislation and policies to improve care and facilitate timely flow and hand-offs across services.

Figure 1

Measure	2009/10 Performance	2010/11 Performance	Result
% ALC Patient Days : acute	9.20%	Q3: 9.29%	Improved performance, approaching target of 8.3%.
Rate of Palliative deaths in hospital	51.80%	50.20%	Improved when compared to the same period of last year.
Rate of new LTC referrals from hospital	34%	30%	Improved by 4% compared to fiscal 09/10.
# of applicants on LTC Wait List	1,106	919	Improved with right people (who have no other choices) on the wait list when compared to the same time last fiscal.

3a) i) Capacity Strategy
Description:
In addition to significant community investments, the MH LHIN, in partnership with the Ministry of Health and Long Term Care is supporting capital investments in hospitals across the LHIN. Hospital occupancy is over 95% and the need is great to enhance hospital capacity to meet the current and future needs of a growing population.
Current Status:
▪ The LHIN has endorsed and/or supported the following hospital capital planning initiatives: • Halton Healthcare Services – new Oakville site – the replacement of the existing site with a new hospital will create capacity for 457 beds with planned opening in 2014/15. • Halton Healthcare Services – Georgetown site – the program and service component of a pre-proposal to expand the Emergency Department. • Halton Healthcare Services – Milton site – the redevelopment of the Milton Hospital to support increased ED, Ambulatory Care and related inpatient obstetrical and medical/surgical capacity. • Credit Valley Hospital – Phase III Priority areas capital project which would increase capacity in critical care and surgical services. Phase II of construction is nearing completion which will allow for increased capacity in the near-term for rehabilitation, surgery, perinatal and paediatric beds. • Trillium Hospital – the program and service component of a pre-proposal to redevelop and expand the Mississauga and West Toronto sites. • Trillium Hospital – redevelopment of 220 long-term care home beds which will increase capacity for frail seniors that need this level of care. ▪ Two MH LHIN hospitals (Credit Valley Hospital and Trillium Health Centre) are planning for implementation of the new Mississauga Academy of Medicine (MAM) in partnership with the University of Toronto. There will be an extensive residency program with clinical facilities available at both hospital sites. The LHIN is supportive of the expanded roles of both hospital corporations as teaching facilities.

GOALS
Goal(s)
▪ Capacity increases / improvements are embedded throughout the document. Goals / measures that are specifically identified as related to capacity are demarked with a **(C).** ▪ The MH LHIN will continue to work with the provincial government to achieve investments in all of these important projects to expand the physical capacity of the HSPs in the MH LHIN to serve the growing population of the MH LHIN. ▪ For all of the capital investments, planning and release of multi-year government funding in post construction operating plan (PCOP) funding is critical to address the expanding capacity needs and ED / ALC pressures in the MH LHIN brought on by a growing and aging population.

3b) Integrating Health Care in the Mississauga Halton LHIN

Description:

The MH LHIN mission is "To lead health system integration" and our vision is "a seamless health system for our communities by promoting optimal health and delivering high quality care when and where needed". This has been the basis for our efforts to improve the patient/client experience through improving:

1. Access and Coordination of services
2. Quality and Safety in the delivery of services
3. Stewardship and accountability in the public interest.

Current Status:

Integration initiatives currently in progress in the MH LHIN:

Hospital Lead:

a. Proposed merger of Trillium Health Centre and Credit Valley Hospital
b. Regional Program for Maternal /Newborn
c. Regional Program for Children and Youth
d. Regional Chronic Disease Prevention and Management (CDPM): COPD Community Outreach Pilot
e. Transformation and Integration of hospital Complex Continuing Care (CCC) and Rehabilitation services

Community Lead

f. Ontario Integrated Behavioural Support System Project
    i. Behavioural Support Unit, Sheridan Villa, including a first year evaluation
    ii. Behavioural Support Systems Pilot, implementation if MH LHIN approved for a pilot project.
g. Mental Health and Addictions:
    iii. Regional Program for Eating Disorders for Children and Youth
    iv. Transitions from Youth to Adult Services
    v. Explore opportunities for broader program integrations with Mental Health and Addictions health service providers
h. Expanded CCAC role: Integration through coordination and partnering of LHIN-wide agencies for CCAC centralized eligibility process for referrals to CCC/Rehab, Assisted Living and Adult day Service to improve the flow of clients/patients through the transition points across the continuum of health care services.
i. Integrated Palliative Client Care: As a Spotlight LHIN for the Integrated Client Care Project – Palliative care, in collaboration with the Ontario Association of CCAC, Health Quality of Ontario, and the MH CCAC, hospital and CSS and hospice agencies to improve the system integration of palliative services across the continuum of care.

GOALS and ACTION PLANS
Goal(s)
▪ Improve access to and quality of care within key clinical services across the MH LHIN. ▪ Maximize capacity across the LHIN. ▪ Improve use of resources to achieve patient care goals.
Consistency with Government Priorities:
The goals and actions align with several Ministry priorities including: ▪ "Strengthening Home Care Services in Ontario 2008" Integrated Client Care Project ▪ Aging at Home Strategy ▪ Maternal/Newborn Access to Care Strategy ▪ Mental Health and Addictions Strategy ▪ Provincial Expert Panel on Rehabilitation and Complex Continuing Care ▪ Provincial Integrated Behavioural Support System Project

Action Plans/Interventions

	2011/12	2012/13	2013/14
Proposed Voluntary hospital Merger between Trillium and Credit Valley hospitals: Respond to hospitals' request for voluntary merger by: o Assessment of proposal within context of LHIN IHSP priorities o Conduct LHIN independent community consultation o Assessment/review of hospitals' due diligence report and resulting hospital Board's decision	100%		
Ongoing assessment of service implications as hospital planning continues over next several years.	TBD	TBD	TBD
Maternal Newborn Child and Youth Regional Programs: Based on the planning work to date, a detailed implementation plan was developed to design the Maternal, Newborn, Child & Youth (MNCY) Regional Program: Detailed design work.	50%	50%	
Regional Complex Continuing Care and Rehabilitation Program:			
• Redesign of CCC services, scope and siting	25%	25%	50%
• Phase 1 implementation at THC	25%	25%	50%

• Redesign of Rehab services	25%	25%	50%
COPD Community Outreach Pilot, implementation.	100%		
Ontario Integrated Behavioural Support System Project: • Behavioural Support Unit at Sheridan Villa LTC Home: First year evaluation. • Implementation of the Behavioural support Pilot, if given ministry approval with funding.	 100% 100%		
Mental Health & Addictions: • Implement a regional Eating Disorders Program for children and youth, led by Halton Healthcare Services • Work with HSPs to implement a transitional Aged Youth Protocol • Explore opportunities for greater integration of mental health & addiction services through governance to governance engagement.	 50% 50% 25%	 50% 50% 50%	 25%
Expanded CCAC Role: • CCAC and LHIN communication of CCAC expanded role through local stakeholder engagement. • Develop high-level implementation plan. • Implementation of plan.	 100% 100% 25%	 25%	 25%
Integrated Client Care Project for Palliative Care: • Launch of the project. • Design of an integrated health care system for palliative care services. • Regional structure developed for ongoing quality improvement for palliative care.	 25% 75% 50%	 50% 25% 50%	 25%

How will we measure success?

Demonstration of a successful integration, evidenced by seamless transitions (favourable client satisfaction scores and appropriate wait times) and continuum of care options that meet patients / client needs (e.g. available specialized programs such as behavior unit, express restore beds, enhanced homecare).

What are the risks/barriers to successful implementation?
▪ Availability of health human resources to implement programs/services. ▪ Community partners not able to offer suitable space for clinics. ▪ Readiness to implement regional programs/services.

3c) Prevention and Management of Chronic Diseases
Description:
Good management of a chronic disease can help prevent the onset of multiple conditions as people age. This is important for individuals, and also for the health system. As our population gets older, there will be more people with chronic conditions such as diabetes, asthma, heart disease, arthritis, and high blood pressure. This will place significant pressure on local health system resources. We can also expect increased visits to family doctors and emergency rooms. Patients with multiple chronic conditions tend to have longer hospital stays, higher health care costs, increased mortality, and higher hospital readmission rates.
Current Status:
▪ Halton Healthcare Services is the host agency for the Diabetes Regional Coordinating Centre (DRCC) in the MH LHIN. ▪ In keeping with the goals of the Ontario Renal Network (ORN), the MH LHIN Renal Integration Steering Committee was established with a dual reporting relationship to the Clinical Integration Program Oversight Committee (CIPOC) within the MH LHIN and to the ORN. Key areas of focus for this group include preventing or delaying the need for dialysis, broadening appropriate chronic kidney disease patient care options and improving the quality of all stages of chronic kidney disease care. ▪ A "Regional CKD Program Implementation Plan" has been developed. ▪ 90 individuals with chronic diseases attended a LHIN-funded self-management program. ▪ The LHIN funded and launched an initiative to reduce avoidable ED visits, hospital readmissions and length of stay for individuals with Chronic Obstructive Pulmonary Disease (COPD). The goal is to improve access to community based care based on best practices. This work will continue in 2011/12.

GOALS and ACTION PLANS
Goal(s)
▪ Improve access to integrated diabetes services. ▪ Improve access to integrated continuum of Chronic Kidney Disease (CKD) services across the MH LHIN. ▪ Enhance the self-management supports for individuals with chronic conditions.
Consistency with Government Priorities:
The above goals and objectives are directly aligned with the province's priority on prevention and management of chronic conditions including the Diabetes Strategy, Ontario Renal Network strategy.

Action Plans/Interventions

	2011/12	2012/13	2013/14
Increase access to home therapies for individuals with CKD in the MH LHIN by supporting the Ontario Renal Strategy:			
• Implement Home Hemodialysis Program at the Burlington satellite unit.	100%		
• Continue to implement and evaluate Peritoneal Dialysis in at least 2 Long Term Care Homes.	100%		
• Support Credit Valley Hospital to implement and monitor the "Grow Home" dialysis therapy initiative at Credit Valley Hospital.	50%	50%	
Implement and evaluate initiatives to improve access to a continuum of community based programs/services for individuals with Chronic Obstructive Pulmonary Disease (COPD).	80%	20%	
Support the implementation of the provincial Self-Management Strategy.	100%		
Increase access to coordinated diabetes programs by supporting the implementation of the Ontario Diabetes Strategy within the MH LHIN.	50%	50%	

How will we measure success?

- Minimum of 2 Long Term Care Homes implementing Peritoneal Dialysis.
- Increased number of individuals receiving home dialysis.
- Increased number of individuals with chronic disease and health care providers attending self-management workshops.
- Report with recommendation for a community based approach to COPD.
- A common referral form and central intake process is developed for Diabetes Education Programs.
- Mobile diabetes outreach sites are implemented and evaluated.

What are the risks/barriers to successful implementation?

- Don't reach Provincial targets for home therapies.
- Delay in implementation of Home Hemodialysis Program.

3d) Integrating Mental Health and Addictions Services

Description:

Mental illness, substance abuse and gambling has a significant impact on Ontarians, it reduces their quality of life and impacts their health, finances, and relationships. Across the MH LHIN, the need for mental health and addictions services is increasing. In recent years, there have been increasing numbers of people with mental health and addiction issues returning to our hospital emergency departments. People with mental health and addiction challenges often have long wait times for assessment and services. Addressing gaps in services and wait times can reduce the number of non-urgent cases treated by emergency departments.

This priority addresses the challenges facing people living with mental illness and/or addictions and their families in accessing a fragmented system, through a multi-faceted approach to promote service integration. This fragmentation is exacerbated for transitional aged youth (16-24 years) transitioning from the youth services to the adult services.

Current Status:

- Mental Health and Addiction services provide a range of services to people living with mental health and addiction problems.
- The MH LHIN funds 12 mental health and addiction service organizations, together providing:
  - Assertive Community Treatment
  - Case Management
  - Counseling and Treatment
  - Crisis Response
  - Employment Support
  - Peer Support
  - Support for Seniors
  - Supported Housing
  - Concurrent Disorders
  - Residential Treatment
- A major initiative launched in 2010/11 was the integrated Community Concurrent Disorders Program (CCDP). The program provides enhanced integrated community services for people dealing with both substance abuse and mental health issues. The CCDP is led by the Canadian Mental Health Association - Halton Region (CMHA-HRB) in a partnership with 4 other MH LHIN HSPs. These 5 HSPs have developed common intake, referral and consent forms as well as implemented common assessment (Gain Short Screener) for concurrent disorders across the LHIN. They have one common data repository collecting statistics allowing for more detailed analysis of MH LHIN trends in order to adjust the program as needed.
- The LHIN's work in 2011/12 will be informed not only by the local needs noted above, but also by the Ontario government's 10 year strategy for mental health and addictions. The two main areas of focus for the new strategy: how to redesign the mental health and addictions services to best meet the needs of individuals; and how to create the conditions in communities to reach optimal mental health and well-being.

GOALS and ACTION PLANS

Goal(s):

Improve:

- Access to mental health and addictions services.
- Community mental health supports to reduce ED visits and hospital stays.
- Access to early diagnosis and treatment.

Consistency with Government Priorities:

With the priority to promote integration and improve access to mental health and addiction services, the MH LHIN is in alignment with provincial strategies. Specifically, these goals and objectives directly support the government's Mental Health and Addictions Strategy. Our objectives will also positively influence the priority on ED Service improvement by diverting visits to the ED as individuals will obtain services in the community.

Action Plans/Interventions

	2011/12	2012/13	2013/14
Collaborate with Health Service Providers to refine the CCDP and ensure on-going performance goals are being met and that the program serves as an excellent example of collaborative integration for the MH LHIN.	100%		
Collaborate with health service providers to implement the Ministry's 10-year Strategic Plan.	10%	15%	25%
Fully implement the Ontario Common Assessment of Need (OCAN) tool, the Addiction Assessment tool (ADAT) and the GAIN Short Screener Assessment tool.	100%		
Explore opportunities for greater integration of community mental health and addiction programs and services [see "Integrating Health Care in the MH LHIN," Page 19].	50%	50%	

How will we measure success?

- Reduce the number of repeat unplanned emergency visits within 30 days for mental health conditions [see Figure 1, Page 24].
- Reduce the number of repeat unplanned emergency visits within 30 days for substance abuse conditions [see Figure 1, Page 24].

What are the risks/barriers to successful implementation?
▪ The readiness of the service providers to expand on system integration opportunities.

Figure 1

Intergrating Mental Health and Addictions Services

		YE Fiscal 09/10	Interim Q1 10/11	Target 11/12
Rate of unplanned emergency visits within 30 days for mental health conditions	Reduction in the number of repeat unplanned emergency visits within 30 days for mental health conditions	15.6	14.6	12.6%
Rate of unplanned emergency visits within 30 days of substance abuse conditions	Reduction in the number of repeat unplanned emergency visits within 30 days for substance abuse conditions	20.3	19.2	17.4%

3e) Enhancing Seniors' Health, Wellness and Quality of Life
Description:
Age is the greatest predictor of increased prevalence of illness and consequently the utilization of health care services. Over the next 25 years, the fastest growing age cohort in the MH LHIN is those over the age of 75. By 2036, the 65+ age group 20% of the population, up from 11% today. Patients age 75+ are most likely to have difficulty transitioning back home after an acute care episode and will likely be designated as ALC during their stay in hospital. These patients represent 85% of the ALC patient days in hospital. The current system of services for seniors is fragmented and difficult for consumers and families to navigate. Opportunities to improve access and service delivery through enhanced integration, coordination, communication and client-focused care have been identified by both consumers and health care service providers.
Current Status:
A number of initiatives have been undertaken by the MH LHIN through the Aging at Home strategy and the Home first approach, to improve access and quality of care for high needs seniors to better support them in their homes in the community. MH LHIN has supported, through its IHSP planning process , the development of a framework for Specialized Geriatric Services. Trillium Health Centre is the lead in the implementation of the current programs across the 3 hospitals. The programs include falls prevention, urgent geriatric assessment clinics, continence program, geriatric and geriatric mental health outreach services. The hospitals are participating in the provincial Seniors Friendly Hospital Initiative.

GOALS and ACTION PLANS
Goal(s)
▪ Achieve the best combination of home and community services for "at risk" seniors. ▪ Improve access to and coordination of services for seniors. ▪ Support seniors in managing their own health, wellness and quality of life.
Consistency with Government Priorities:
The above goals and objectives are directly aligned with the province's priorities to reduce ED wait times and ALC days, specifically throughout the Aging at Home Strategy.

Action Plans/Interventions

	2011/12	2012/13	2013/14
Regional Specialized Geriatric Program – led by Trillium Health Centre: • Implementation of an integrated program for specialized geriatric services across all hospital sites.	100%		
Provincial Seniors' Friendly Hospital Initiative: • Implementation plan developed. • Hospital survey completed. • Implementation of specific seniors' friendly strategies across the hospitals.	100% 100% 25%	25%	25%

How will we measure success?

- RM&R adopted and implemented.
- Seniors Geriatric Services (SGS) available, coordinated across all hospital sites and utilized.
- Enhanced CCAC services available, coordinated and utilized.
- Senior Friendly Hospital Strategy implemented in hospitals.

What are the risks/barriers to successful implementation?

- Community and hospital readiness to achieve transformational culture shift for a senior friendly environment that is more tolerant of individual client choice of risk.

3f) Strengthening Primary Health Care

Description:

When residents in the MH LHIN need health care, they most often turn to primary health care services. Visits to family physicians, consultations with nurse practitioners, telephone calls to health information lines, and advice received from pharmacists are just some examples of primary health care services. Primary health care is key to maintaining and improving our health, and to the quality and sustainability of our local health care system.

Reducing wait times, with a special focus on emergency departments, and quality family health care for all Ontarians is a priority of the government. It's important that citizens of the MH LHIN have access to primary health care around the clock which should help to relieve reliance on hospital emergency departments for non-emergency care.

The MH LHIN will work with our primary health care providers to address our priority of transforming and integrating programs and services to improve overall performance in the local health care system. Additionally, we will work with our family physicians:

- To facilitate the increase of family physicians' use of electronic medical records. This will ultimately lead to improved patient care, safety and access to important clinical health information.
- In diabetes management – where primary care is critical to effective patient management.
- In providing continuity of care to mental health & addictions clients.
- To advance our palliative care initiative across the LHIN.

Current Status:

- MH LHIN established a Primary Care Steering Committee to provide advice to the LHIN on Primary Health Care engagement related to our strategic priority.
- Current electronic medical record adoption is one of the lowest in the province at about 30%. Through the eHealth office, the LHIN has established a CW/MH LHIN Physician eHealth Steering Committee to address local physician eHealth adoption.
- The LHIN liaises with Health Care Connect to identify the need for patients who don't have a family physician to get the care they need.
- The Ministry approved a new Family Health Team for the MH LHIN. The LHIN now has 7 Family Health Teams.
- The LHIN is working closely with the Health Force Ontario Partnership Coordinator to support the recruitment of physicians to the MH LHIN.
- The LHIN will be home to a new Medical Academy of Medicine offered through the Credit Valley Hospital and Trillium Health Centre beginning in 2011.
- The LHIN sponsored 1 accredited medical education events for physicians.

GOALS and ACTION PLANS

Goal(s)

- Improve access to family health care.
- Increase family physicians' use of electronic medical records (EMR).

Consistency with Government Priorities:

Strengthening the primary health care sector aligns with the government's Open Ontario Plan by providing more access to health care services while improving quality and accountability for patients. As well, it supports many MOHLTC priorities including our ability to reduce ED wait times and improve the population health of people with diabetes.

Increasing the rate of EMR adoption will promote information flow between and within health care providers reducing the amount of duplication that currently takes place. As well, real time access to information can facilitate quicker decisions to take place with respect to service delivery thus improving patient transition out of the hospital for when their acute care episode is completed.

The ABP is also consistent with the Ontario Government priorities related to:

- Interprofessional Care: A Blueprint for Action in Ontario: HealthForceOntario (July 2007);
- Connect more people without a family physician to primary care; and
- Healthy Ontarians.

Action Plans/Interventions

	2011/12	2012/13	2013/14
Develop a community engagement plan for primary health care that reflects the priorities of the Integrated Health Service Plan.	100%		
Strengthen communication between hospitals and primary health care providers.	50%	50%	
Sponsor continuing health education events specifically targeted at one of the LHINs strategic priority program areas.	*On-going*		

How will we measure success?

- A primary health care community engagement plan is developed and implemented.
- Improved communication between hospitals and primary health care providers.
- Plan and host an educational event for one of the IHSP priorities.

What are the risks/barriers to successful implementation?

- Providers' availability to participate in events.

3g) eHealth
Description:
eHealth is a critical enabler to our strategic priorities. There are opportunities to improve LHIN wide information integration and build capacity within our community. Over the next few years, MH LHIN will take the leadership role to build the infrastructure to support information management across the LHIN. We will work in collaboration with other LHINs, particularly the GTA Cluster. We will leverage the existing information assets embedded in our HSPs and implement a shared Information Technology/Information System. MH LHIN will continue to align our eHealth initiatives with Ontario's eHealth Strategy. In particular, we will be supporting the implementation of: ▪ Diabetes Management. ▪ Medication Management. ▪ Wait Times. ▪ Foundational Priorities. ▪ Information Systems ▪ Clinical and Operational Initiatives ▪ Technology Platform Initiatives ▪ Enabling Initiatives
Current Status:
• Mississauga Halton eHealth and Physician eHealth strategies continue to be implemented by our eHealth team which consists of a dedicated eHealth Program Manager and shared Regional Chief Information Officer, Project Management Office (PMO) Lead and Project Planner Controller. • Working with the LHIN's stakeholders Health Service Provider and primary care providers, the e-Health team is responsible for the planning and execution of regional and e-Health Initiatives. Delivery of all foundational components to support provincial eHealth initiatives, such as the Diabetes Registry, is in progress and will continue throughout the next several months. • Over the past year, the team has also focused on the implementation of the Community Care Information Management solutions, which include common patient assessment record and enhanced business systems for the Community and Mental Health and Addictions sectors • Increasing the adoption of physician EMR systems within the LHIN continues to be a key focus. The eHealth team is working closely with the Ontario MD as they execute on their EMR adoption program across the province. ▪ The eHealth PMO continues to evolve and this quarter has implemented an enterprise Project Portfolio Management (PPM) tool (Eclipse) to facilitate improved project planning and tracking. Initiatives that identify efficiencies through the consolidation of services and the introduction of technology that improves the delivery of care are also underway.

GOALS and ACTION PLANS
Goal(s)
▪ To be seen as a leader in the implementation of eHealth projects that support the sharing of clinical information across the health care provider system. ▪ Provide the infrastructure and enablers required for the achievement of all strategic initiatives. ▪ Improve information sharing within communities and across the continuum of care. ▪ Improve the management and prevention of chronic diseases.
Consistency with Government Priorities:
MH LHIN will continue to align our eHealth initiatives with the government priorities set out in Ontario's eHealth Strategy.

Action Plans/Interventions

	2011/12	2012/13	2013/14
Create a Regional Privacy Model.	25%		
Implement a Community Services Provider (CSP) Portal.	100%		
Create a comprehensive communications plan to reach out to providers and patients about the potential of provincial eHealth initiatives and their implementation over the next few years.	100%		
Common Health Information System (HIS) Foundational Components (Regional Governance, Project Management, Privacy & Security, Technology, Communications & stakeholder engagement, Adoption and Sustainably and Regional Technology Capacity). [3 – 5 Year Implementation Program pending funding.]	15%	25%	25%
* Diabetes Registry.	50%	50%	
* Medication Management.	25%	25%	25%
* GTA West Diagnostic Imaging Repository.	100%		
* Connecting GTA – Provider Portal and Health Information Access Layer (HIAL).	50%	25%	25%
* Continuation of the Ontario MD physician Electronic Medical Record Adoption Program.	65%	5%	5%

Community Care Information Management (CCIM) Program initiatives.	50%	50%	
Wait Times – Resource Matching and Referral – Phase II.	75%	25%	

* *Denotes eHealth Ontario sponsored project.*

How will we measure success?

- Improved sharing and access of information across LHIN health care providers.
- Increased implementation and adoption of electronic medical records by Primary Care providers. Currently the target set by Ontario MD is 65% provincial adoption by 2012.
- Improved ability to drive results through availability and transparency of reporting through the LHIN wide adoption of Physician Report Manager and access to patient and provider portals.
- Improved access to integrated diabetes services through the implementation of the Diabetes registry which is accessible to patients and care providers within the LHIN.
- Improved access to information required for patient referrals will be realized through the implementation and adoption of Community Sector Portal, completion of phase 2 of the Resource Matching and referral project.
- Optimized IT/IS/IM investments by organizing and leveraging existing assets through the adoption of opportunities identified in business cases which reduce cost and improve ease of access.
- Foundational Outcomes identified in the current state section once completed and operationalized, will ensure the LHIN's ability to successfully adopt eHealth solutions.

What are the risks/barriers to successful implementation?

- Limited capacity in some health service providers to participate fully in eHealth initiatives.
- Ability to effectively engage stakeholders to support implementation and adoption of initiatives.
- Delay in the release of funds by eHealth Ontario has a direct impact on implementation timelines and deliverables.

3h) French Language Health Services

Description:

The *French Language Health Services Act, Ontario 1986,* guarantees the right of French-speaking Ontarians to communicate with the government and receive services in French.

The Francophone population in the MH LHIN consists of 18,490 residents (1.8%) whose mother tongue is French and we expect to see the Francophone population grow to approximately 35,000 under the new Inclusive Definition of Francophones (IDF).

Key challenges facing this population:

- The Francophone population is dispersed across the LHIN and bordering LHINs.
- The population is not homogenous (i.e., new Canadians, Canadian Francophones).

Current Status:

- In December 2010, the Ministry approved a new Francophone Planning Entity for the Central West, Toronto Central and Mississauga Halton LHINs. A key activity for 2011/12 will be establishing an Accountability Agreement and building relationships with the FLS planning entity.
- A French language Services Consultant has been recruited for the French Language Services portfolio in MH LHIN.
- MH LHIN has developed and implemented a French Language Services Plan to meet its requirements as a crown agency under French Language Services Act and as a local health planner under LHSIA.
- Quarterly meetings with the local Francophone Leaders of Centre de services de santé de Peel et Halton Inc. (CSSPH) for broad consultation and input to identified local needs, health system planning, and human resources availability.
- The MH LHIN continues to work with the five (5) GTA LHINs on Francophone planning and community engagement through the GTA LHIN Community Engagement meeting.
- As part of its community engagement activities, the LHIN participated in more than 10 focused community engagement events with Francophone community organizations such as CSSPH, Notre Santé, Notre Priorité, Réseau de soutien à l'immigration francophone du Centre Sud Ouest de l'Ontario, Table de Concertation des services en français de Peel and CÉNIP.
- All identified HSPs have completed a HSP French Language Services Implementation Plan outlining the actions to enhance access to French services. LHIN staff is regularly meeting with the five 'identified' Health Service Providers (HSP)
- MH LHIN and two identified HSPs participated in the French Link, community event organized by Peel Francophone Steering Committee
- MH LHIN conducted a Stakeholder analysis of the Francophone community in its geographical region.
- MH LHIN and all identified HSPs participated in a community engagement event aimed at Francophones to share information on programs available in French and assess needs of Francophones.

GOALS and ACTION PLANS
Goal(s)
▪ Improved access to French Language Health Services (FLHS) for Francophone residents of the MH LHIN.
Consistency with Government Priorities:
Improving access to French Language Health Services (FLHS) for Francophone residents of the MH LHIN is in alignment with the government priorities.

Action Plans/Interventions

	2011/12	2012/13	2013/14
Enter into agreement with the selected French Language Health Planning Entity for Region 3.	100%		
Recruit members from various community groups to represent the local Francophone community and become an expert collaborative to the MH LHIN in an attempt to enhance access of French services in the MH LHIN.	100%		
Develop and implement a Francophone community engagement plan.	100%		
Work with identified HSPs to enhance access to French language services in the MH LHIN through their FLS Implementation Plans.	100%		
Develop and implement a FLS work plan to enhance access to French services in the MH LHIN.	100%		
Implement the MH LHIN French Language Health Service Indicator Tool for evaluating French services in the LHIN.	50%	50%	
Work with neighbouring LHINs (Central West LHIN) in implementing a Francophone healthcare needs assessment.	100%		
Review French Language Services in H-SAA and M-SAA	100%		

How will we measure success?
▪ Program and services deemed priorities by Francophone communities are available in French. ▪ French-speaking stakeholders and entities are included in planning and decision-making. ▪ Connect more Francophones without a family doctor to culturally appropriate primary care.
What are the risks/barriers to successful implementation?
▪ Supply of French language health professionals.

3i) Engagement with Aboriginal People
Description:
There are approximately 8,280 aboriginals within the MH LHIN representing about 0.7% of the population. Most Aboriginal people in the LHIN service areas self-identified as having First Nations ancestry (85%) and/or Métis (26%) ancestry. Few people in either the APS or in the Aboriginal Resident Survey self-identified as Inuit. Members of the aboriginal community seek health and social services through mainstream providers or travel to Toronto to seek culturally sensitive services through Anishnawbe Health (the only Aboriginal health centre in the Greater Toronto Area, excluding Hamilton).
Current Status:
▪ The MH LHIN continues its commitment to exploring opportunities for community engagement with Aboriginal people by meeting with Aboriginal leaders through the First Nations, Métis and Inuit Health Needs Assessment Committee, in collaboration with Central West LHIN to implement the next steps of the Health Needs Assessment Report. Specifically, representation from the Credit River Métis Council, the Peel Aboriginal Network, and the Métis Nation of Ontario are represented on the committee. ▪ A work plan based on the next steps of the health needs assessment report has been developed and is currently being implemented. It includes community engagement activities and communication strategy with Métis Nation of Ontario and Peel Aboriginal Network Aboriginal.

GOALS and ACTION PLANS
Goal(s)
Work with the Aboriginal community to better understand and address issues of access to care.
Consistency with Government Priorities:
Working with the Aboriginal community to better understand and address issues of access to care in the MH LHIN is in alignment with government priorities.

Action Plans/Interventions

	2011/12	2012/13	2013/14
Develop a community engagement strategy for the Aboriginal communities.	100%		
Implement a community engagement plan to support a collaborative relationship with First Nations, Métis and Inuit communities based on the Health Needs Assessment report.	50%	50%	
Work with the Peel Aboriginal Steering Committee, Region of Peel to participate in joint community events to promote common goals of engagement.	100%		
Develop and implement an Aboriginal work plan in collaboration with the Health Needs Assessment Committee.	100%		
Develop an inventory of services available to Aboriginal communities in MH LHIN.	50%	50%	
Develop an inventory of traditional healers in collaboration with Peel Aboriginal Network and Métis Nation of Ontario.	50%	50%	

How will we measure success?

- Community engagement strategy for the Aboriginal communities developed.
- Implementation of a community engagement plan.
- Complete inventory of traditional healers in collaboration with Peel Aboriginal Network and Métis Nation of Ontario.

What are the risks/barriers to successful implementation?

- Readiness of HSPs to provide culturally responsive services. Mitigating strategy – continue to work with the HSPs and Aboriginal community to increase awareness of needs.

4. LHIN OPERATIONS & STAFFING TEMPLATES

LHIN Operations Spending Plan				
LHIN Operations Sub-Category ($)	2009/10 Actuals	2010/11 Actuals	2011/12 Planned Expenses	2012/13 Planned Expenses
Salaries and Wages	2,358,722	2,467,081	2,398,967	2,511,225
Employee Benefits				
HOOPP	224,014	244,390	280,399	293,520
Other Benefits	239,615	241,501	436,176	454,719
Total Employee Benefits	**463,629**	**485,891**	**716,575**	**748,239**
Transportation and Communication				
Staff Travel	18,937	15,802	15,350	12,000
Governance Travel	10,019	8,129	10,000	10,000
Communications	47,912	34,015	40,000	35,000
Other	808			
Total Transportation and Communication	77,676	57,946	65,350	57,000
Services				
Accommodation	180,579	138,422	138,224	138,224
Advertising	400	12,565	15,000	5,000
Banking	-	-	-	-
Community Engagement		-	-	-
Consulting Fees	233,017	16,177	94,000	60,000
Equipment Rentals	29,220	28,321	30,000	30,000
Governance Per Diems	167,300	128,300	173,105	173,105
LSSO Shared Costs	359,059	404,926	429,931	359,500
Other Meeting Expenses	31,156	34,005	40,000	35,000
Other Governance Costs	23,957	40,836	45,000	40,000
Printing & Translation	12,101	12,525	18,000	18,000
Staff Development	46,691	17,117	25,000	25,000
LHINC	12,286	50,000	50,000	50,000
Other Services	23,669	36,693	36,000	36,000
Total Services	1,119,435	919,887	1,094,260	969,829
Supplies and Equipment				
IT Equipment	3,983	59,367	6,000	6,000
Office Supplies & Purchased Equipment	37,292	51,003	51,141	40,000
Other	56,947		-	-
Total Supplies and Equipment	98,222	110,370	57,141	46,000
Capital Expenditures	93,885	9,196	-	-
LHIN Operations: Total Planned Expense	4,211,569	4,050,370	4,332,293	4,332,293
Annual Funding Target	4,268,293	4,332,293	TBD	TBD
Variance	56,724	281,923	TBD	TBD

Note to the above:

Amortization of Capital Items not included in the above

Other funding initiatives are not included in the LHINs Operation Spending Plan

LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2010/11 Actuals as of Mar. 31/10 FTEs	2010/11 Forecast FTEs	2011/12 Forecast FTEs	2012/13 Forecast FTEs	2013/14 Forecast FTEs
CEO	1	1	1	1	1
COO	1	1	1	1	1
Director	3	2	2	2	2
Manager Corporate Services	1	1	1	1	1
Senior Consultant	8	8	8	8	8
EA	1	2	2	2	2
AA	2	1	1	1	1
Receptionist	1	1	1	1	1
Program Asst	1	1	1	1	1
Mgr Comm Eng & Communications	1	2	2	2	2
Planning Analyst	1	1	1	1	1
Manager Finance & Risk	0	1	1	1	1
Sr Lead Funding & Allocation	1	1	1	1	1
Financial Analyst	1	1	1	1	1
Sr Information Lead	1	1	1	1	1
Special Project Coordinator	1	1	1	1	1
French Language Services Consultant	1	1	1	1	1
Project Mgmt Support	0	1	1	1	1

5. COMMUNICATIONS PLAN

Objectives

Along with the Integrated Health Service Plan 2010-13, the ABP is one of the critical documents that guide the work of the MH LHIN.

The IHSP identifies the priorities of the MH LHIN and defines the activities to be undertaken from 2010 to 2013 that will move us closer to an integrated health system of care.

The ABP demonstrates progress made toward reaching the IHSP goals and objectives and also provides the opportunity to fine-tune strategies for the upcoming year. It provides a framework for communicating the impact local decision making has on health care delivery in our communities to stakeholders.

Context

Under the Local Health Systems Integration Act (LHSIA) 2006, and the Ministry-LHIN Performance Agreement (MLPA), LHINs are required to publish their ABP to inform stakeholders about the LHIN's strategies and initiatives for addressing IHSP priorities. The MH LHIN's ABP communication plan ensures that all stakeholders have full and easy access to our strategic and operational plans.

The document also includes an overview of the activities to support key provincial activities and a management plan to identify the future challenges faced by our health care system.

LHINs are responsible for engaging health care providers, consumers, and the general public in the work that is required to build an accessible and sustainable quality health care system.

The ABP also provides LHIN funding requirements for the next three years, with particular focus on the 2011/12 fiscal year.

Target Audiences

The MH LHIN deals with many stakeholder audiences, each with its own and often differing, understanding of the health care system and the role of the LHIN in funding, planning and integrating the system. Stakeholders can be categorized into the categories and sub-categories noted below.

- MH LHIN residents
- Ministry of Health and Long-Term Care
- Internal to the MH LHIN:
  - MH LHIN Board of Directors
  - MH LHIN Senior Leadership Team
  - MH LHIN Staff
- MH LHIN Advisory and Reference Groups:
  - MH LHIN Hospital / LHIN / CCAC CEO Group
  - Clinical Integration Program Oversight Committee (CIPOC)
  - MH LHIN ED Leaders Group
- Internal to the Health Care System:
  - Hospitals
  - Mississauga Halton CCAC
  - Long-term Care Homes
  - Community Support Service Agencies
  - Mental Health and Addictions Agencies

- External Stakeholders:
  - MPPs
  - Municipal Leaders
  - Media

Strategic Approach & Tactics

The ABP describes many key initiatives to advance the priorities of the IHSP and each of these has its own communication strategy. In addition, the MH LHIN has an overall strategic communications plan that outlines the various tactics used to communicate with stakeholder groups.

This section of the ABP will therefore focus on the strategy of building awareness and understanding of this document among all stakeholder groups.

Stakeholder	Timing	Tactic	Details
DRAFT ABP			
MH LHIN Senior Leadership	November 2010-January 2011	Meetings/formal presentations	Senior Leadership will review and provide feedback on the draft ABP
MH LHIN Board of Directors	January 2011	Open Board meeting	Briefing Note on ABP at January Board Meeting
Ministry of Health and Long-term Care	January 31, 2011	Electronic Submission	Submission of draft ABP to MOHLTC
MH LHIN Staff	February 2011	Email	All staff will be notified via email when the draft ABP has been sent to the MOHLTC. The document will be available internally on a shared drive.
Final ABP			
MH LHIN Hospital / LHIN / CCAC CEO Group	May-July 2011	Meetings/formal presentations	CEO Group will review and provide feedback as the ABP is finalized
MH LHIN Senior Leadership	July 2011	Meetings/formal presentations	Senior Leadership will review and provide feedback on the final ABP, and will have final approval prior to presenting to the Board for its support and final approval

Stakeholder	Timing	Tactic	Details
MH LHIN Board of Directors	July 2011	Open Board meeting	A summary presentation and the full text of the final ABP
MH LHIN Staff	July 2011	Email	All staff will be notified via email when the final ABP has been approved by the Board, and available internally on a shared drive
MH LHIN Advisory and Reference Groups	Upon Ministry approval	Meetings/formal presentations	Summary presentation plus full text of ABP
Hospitals / CCAC / Long-Term Care Homes Community Agencies / MH&A Agencies MPPs	Upon Ministry approval	Email notification	An email, from the LHIN CEO, including attachment of full text ABP, in advance of public posting

Appendix: MH LHIN Indicators (MLPA and Other)

System Measures	Baseline (09/10)	Target (10/11)	Baseline/ Performance (10/11)	Target (11/12)
90th Percentile ER length of stay for admitted patients (MLPA/ED P4R) - Hours(1)	38.6	28.4	35.87	25 Hours (Reduce 10% for visits >25 hours; reduce 5 % for visits <=25 hours)
90th percentile ER length of stay for non-admitted complex patients (MLPA/ED P4R) - Hours (1)	7.2	7	6.7	7 Hours (Reduce 10% for visits >7 hours; reduce 5 % for visits <=7 hours)
90th percentile ER length of stay for non-admitted minor/uncomplicated patients (MLPA/ED P4R) - Hours (1)	4.1	4	3.72	4 Hours (Reduce 10% for visits >4 hours; reduce 5 % for visits <=4 hours)
% Admitted LOS target ≤ 8 hours (ED P4R) (2)	39.1%	improve	46.1%	Retired for 11/12
% Non-Admitted: CTAS I, II & III ≤ 8hrs (ED P4R) (2)	91.8%	Maintain	94.8%	Retired for 11/12
% Non-Admitted: CTAS IV & V ≤ 4 hrs (ED P4R) (2)	89.4%	Maintain	92.2%	Retired for 11/12
Time to PIA (ER P4R) (2)	3.8	3.5	3.3	N/A
Time to Initial Assessment (ER P4R)	N/A	N/A	TBD	10% improvement from 10/11 baseline level
Time to Decision to Admit (ED P4R)	N/A	N/A	TBD	Maintain or improve
Time to inpatient bed (ER P4R)	N/A	N/A	TBD	8 hours or less from 10/11 baseline
Percentage ALC Days (1)	9.2%	8.3%	9.7%	8.3%

Notes:
(1) Per MOHLTC M-H LHIN Performance Indicators 2010/11 Annual Report, May 13, 2011 Release
(2) Per March 2011 CCO/ATC ED reports released from DoN (Directory of Networks)

Improving access, quality and sustainability of the health sytem

		YE Fiscal 09/10	Interim Q4 10/11	Target 11/12
Percentage ALC Days	Reduction in the absolute number and percentage of ALC patients and ALC bed days	9.20%	8.10%	8.30%
30 day readmission rates for selected CMG's (Case Mix Groups)	Reduction in the number of readmission to the acute care setting for selected CMG's	14.2	12.6 % *this is Q1 10/11 calculation	13.10%
90th percentile ER length of stay for admitted patients	10% reduction from 10/11 baseine level if above 25 hours		25 hrs	22.5 hrs
90th percentile ER length of stay for non-admitted complex patients	7 hours for non-admitted complex patients		7.0 hrs	7.0 hrs
90th percentile ER length of stay for non-admitted minor/uncomplicated patients	4 hours for non-admitted complex patients		4.0 hrs	4.0 hrs

Intergrating Mental Health and Addictions Services

		YE Fiscal 09/10	Interim Q1 10/11	Target 11/12
Rate of unplanned emergency visits within 30 days for mental health conditions	Reduction in the number of repeat unplanned emergency visits within 30 days for mental health conditions	15.6	14.6	12.6%
Rate of unplanned emergency visits within 30 days of substance abuse conditions	Reduction in the number of repeat unplanned emergency visits within 30 days for substance abuse conditions	20.3	19.2	17.4%

Enhancing Seniors' Health, Wellness and Quality of Life

		YE Fiscal 09/10	Interim Q3 10/11	Target 11/12
Percentage ALC Days for those 65+	Reduction in the absolute number and percentage of ALC patients and ALC bed days for those 65+	16.1%	16.0%	